Formative Evaluation of the Early Childhood Mental Health (ECMH) Initiative

(A Component of the KIDS NOW Program)

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Why is there a need for mental health services at such an early age? What gave rise to the decision to develop and deploy an early childhood mental health program component within KIDS NOW?

- Increasing numbers of children are displaying behaviors indicative of anxiety and depression, over-aggressiveness, high activity levels, or disengagement and lack of curiousity.
- The causes of social, emotional, and behavioral problems in very young children vary, and may include:
    - Genetics are an influence in some disorders such as autism, bipolar disorder, schizophrenia, and attention-deficit hyperactivity disorder.
    - Biological abnormalities of the central nervous system may be caused by injury, infection, poor nutrition, low birth weight, or exposure to toxins such as lead.
    - Family factors such as parental depression, substance abuse, or criminality.
    - Social environmental factors such as poverty and association with maladaptive peers.
    - Traumatic events such as child maltreatment or death of a parent
- Early care and education experiences are often of poor quality, especially for infants and toddlers, yet this is just when the importance of nurturing, language-enriched relationships are so vital.
- Children with developmental difficulties are being suspended from child care settings for uncontrollable behaviors.
- Estimates are that between one-quarter and one-third of young children are perceived as not being ready to succeed in school. For a significant number of these children, concerns center around emotional development.
- Children who have been exposed to violence are particularly vulnerable to compromised emotional development and poor school performance.
- There is a link between emotional development and success in school.
- Brain research indicates that children's emotional development and their ability to manage emotions and behaviors is especially related to early life experiences.
- The roots of emotional problems often lie in caregiving environments that do not meet the needs of children.
- 40% of children with emotional development problems come from families with significantly low income.

Thus, it has been recommended that states establish early childhood mental health programs to (1) enhance the emotional and behavioral well-being of infants, toddlers, and preschoolers to promote early school success(particularly those whose emotional development is compromised by poverty or other risk factors); (2) help parents be more effective nurturers; (3) expand the competencies of nonfamilial caregivers to prevent and address problems; and, (4) ensure that more seriously troubled children get help.

Research Supporting the Need for the Early Childhood Mental Health Program

- *The roots of later healthy emotional and behavioral functioning lie in the earliest relationships that infants and toddlers have with their primary caregivers.* These relationships set the stage for how that child learns to regulate emotions, and how he or she perceives the emotions of others, which, in turn, affects all domains of development, including cognitive learning. Therefore, it is in society's interest to invest in efforts to see that young children get off to a healthy start not just physically, but emotionally.

- *Emotional problems in young children often, although by no means always, can be traced to family caregiving environments that cannot meet children's needs for nurturing and stimulation.* There are many reasons for this—sometimes the caregivers, parents, or others are simply too burdened by their own stresses, or they themselves have had such inadequate parenting that they do not know how to provide the needed nurturing and stimulation. Some parents face special barriers that, in turn, impose special barriers on young children. The literature increasingly points, for instance, to the negative consequences of maternal depression on young children. Substance abuse and domestic violence also take a heavy toll (and often coexist with each other and with depression). Other causes include biological or environmental factors (for instance, relatedto lead poisoning). All this suggests that early childhood mental health strategies need to include attention to family and environmental barriers that make it hard for children to thrive emotionally.

- *Early learning and early emotional development are connected.* Cognitive, behavioral, and emotional functioning, especially in the earliest years, are intertwined more closely than has been previously understood.In particular, a child's emotional status affects early school performance, which in turn predicts later school outcomes. There is also evidence that early child care and learning environments can escalate or inhibit behaviors depending upon teacher/caregiver management skills and relationships with the child. So getting young children off to a positive start in the early school years makes a long-term difference.

- *There is long-standing evidence that, for some proportion of children, behavioral problems visible in the preschool and early school years lead to later conduct disorders.* These in turn, are related to high-cost impacts involving special education and often, juvenile justice. Research also suggests that for these children, intervention before the fourth grade can interrupt the negative cycle.

- *One of the most harmful risk factors to young children, including to their emotional development, is poverty.* Not all poor young children show signs of emotional distress; some are resilient and are in families able to provide a buffer against the most harmful effects of poverty. But with close to 40 percent of all young children under age six in families with incomes at or below 200 percent of the poverty level, the potential risks are great.

- *The more risk factors young children experience, the higher the probability that their emotional and cognitive development will be compromised.* Some of this risk can be mitigated by factors that occur naturally in a child's environment, such as the sustained presence of a caring adult. But for many others, planning intensive and targeted services to children or their families may be required.

From: Knitzer, J. (2001). *Building Services and Systems to Support the Healthy Emotional Development of Young Children An Action Guide for Policymakers.* New York: National Center for Children in Poverty.

Who were the originators of the program? How is the program organized and funded?

Governor Patton's spending plan for the current biennium included provisions for enhancing early childhood (KIDS NOW) by establishing an Early Childhood Mental Health component. This program involves hiring, deploying, and supporting fourteen (14) early childhood mental health specialists, one in each of Kentucky's mental health regions. Regional MH/MR Boards were provided $63,000 per region, who then employed persons with backgrounds and expertise that bridged mental health and early childhood. Expected competencies of these individuals included developmental knowledge, clinical sensitivity and expertise, understanding of family dynamics, consultation skills, and comfort in working with very young children, families and child care professionals.

In actuality, elements of the ECMH initiative have been discussed within a variety of venues in Kentucky for many years, and various organizations have provided some services to this population (albeit in a limited manner). There were a number of "pioneers" who established some of the rudiments of the current program.

- Within DMH, for example, Jim Call and Frances Ryan coordinated the KIST initiative for some time, and there has always been some degree of collaboration and "synergy" between the public health and mental health departments.
- Through quarterly training offered to Comprehensive Care Center personnel, there was some emphasis on this under-funded and underutilized area.
- First Steps, an early identification and family support program, was also instrumental in identifying the social, emotional, and behavioral issues that were barriers to success for young children.
- Within Kentucky IMPACT, a number of Regional Interagency Councils targeted very young children as a priority and dedicated resources (it should also be noted that IMPACT has become a model for regional cross-agency collaboratives in Kentucky).
- Moreover, Head Start became increasingly concerned with the mental health needs of young children (partly in response to changing national standards) and increased services in this area through activities such as contracting with Comp Cares for observation and consultation.
- As schools increasingly utilized school-based mental health services, some began to extend these services downward to pre-Kindergarten levels.
- Recent efforts to improve child care services have pointed up the need for additional services in this area.
- And, participants in training by Dr. Stanley Greenspan on young children and similar training on early brain development (e.g., I Am Your Child) were sensitized to these issues.

Thus, the rudiments of an infrastructure for the current effort have been in place for some time through joint training, networking of cross-agency staff, and a general recognition and commitment that this was a priority need. Clearly, however, the advent of the KIDS NOW initiative, part of the Governor's early

childhood initiative, was the culminating factor that gave rise to the initiation of the present ECMH program.

Who is currently involved? Which organizations/agencies serve as core constituencies? What are their intentions? Information needs?

The Early Childhood Mental Health project is a collaboration between the Division of Adult and Child Health, Department of Public Health and the Department of Mental Health and Mental Retardation Services (DMHMRS) within the Cabinet for Health Services. The lead agency for the project is the Division of Adult and Child Health (Germaine O'Connell, supervisor), with close collaboration from DMH (Beth Armstrong, supervisor). The Department for Public Health (DPH) has lead responsibility for the funding and administration for this program. A Memorandum of Agreement concerning this program has been adopted between the DPH and the Department for Mental Health and Mental Retardation Services (DMHMRS). This MOA allows for the transfer of program support funds to the DMHMRS. These funds will in turn be contracted to each Regional MH/MR Board by the DMHMRS. Additionally, the Governor's Office of Early Childhood (Dr. Kim Townlee) provides a vital role in terms of cross-agency collaboration and interface with the executive and legislative branches of government.

The goal of the ECMH Initiative is to provide mental health consultation to early childhood programs, and assessment/therapeutic services for children age birth to five and their families. The initiative will provide funds for fourteen Early Childhood Mental Health Specialists to be hired, one per Regional MHMR Board. Each Regional MHMR Board will create and fill one full-time position for an ECMH Specialist. This Specialist's time will be devoted solely to the Early Childhood Mental Health Initiative. The job duties of the ECMH Specialist will include the following:

- Provide assessments to children age birth to five with mental health needs at the location most suitable for the child and family;
- Provide therapeutic treatment services (i.e. individual, family, and collateral therapy) to children age birth to five with mental health needs and their families at the location most suitable for the child and family. Specialists are not to devote more than .5 FTE to direct therapeutic treatment services;
- Work closely with local Healthy Start in Child Care consultants and the Health Access and Nurturing Development Services (HANDS) home visitors, and other agencies or programs that serve children birth to five and their families, to provide mental health consultation, assessment and therapeutic treatment services on behalf children age birth to five identified by those programs as needing mental health services;
- Provide free consultation and education services to childcare program staff that serve children age birth to five;
- Assist families with children age birth to five in identifying and accessing needed community resources;

- Provide information and serve as a resource to private physicians and other caregivers through raising awareness of available services and resources for children age birth to five and their families;
- Offer early childhood mental health training to fellow Regional Board staff, as well as other community partners who serve young children;
- Foster community planning for early childhood mental health through local groups and the Community Early Childhood Councils in the area;
- Attend training related to early childhood development and early childhood mental health needs;
- Attend periodic regional consultation and supervision sessions conducted by a statewide early childhood mental health consultant;
- Prepare and submit periodic service reports and evaluation data, and
- Attend quarterly state level meetings of all ECMH Specialists.

What goals does the program have for change in children, for families, and for the service system?

System goals for the initiative include:

- Developing clinical and programmatic knowledge, skill, and experience of program professionals throughout the entire system of care with respect to the mental health needs of very young children (birth to five)
- Increasing accessibility of early childhood mental health services to children and families in need by providing direct (e.g., assessment, therapy) and indirect services (e.g., behavior consultation, training, support) and by enhancing the network of competent providers.
- Strengthening the capacity of child caring systems and providers to serve very young children with social, emotional, and behavioral needs, reducing the rate of exclusion due to these problems and insuring that referrals for specialized services are appropriate.
- Integrating services provided to young children with serious social, emotional, and behavioral needs through cross-training, interagency collaboration, and integrated treatment planning.
- Building more comprehensive and effective systems of care by identifying the scope of needs experienced by these children and families, improving community awareness and planning, and seeking additional funding resources at local, regional, state, and national levels.
- Ensuring that young children experiencing atypical emotional development and their families have access to needed supports.

Child and family goals for the initiative include:

- Reducing presenting problems and issues (e.g., challenging behaviors, inappropriate social interaction, emotional states) that create mismatches and conflict between the child and their immediate environment through direct and indirect intervention.

- Developing parenting and child management skills and improving overall family functioning and cohesiveness through support and training activities.
- Enabling and facilitating opportunities for developmental experiences to promote developmental gains through family and program consultation activities.
- Reducing risk factors that impinge on children and families and exacerbate their developmental vulnerabilities through direct intervention and assisting families with children age birth to five in identifying and accessing needed community resources.
- Strengthening protective factors in the child's and family's immediate environment that can ameliorate stressors and serve to "inoculate" children against the effects of these issues

How was the Evaluation Conducted?

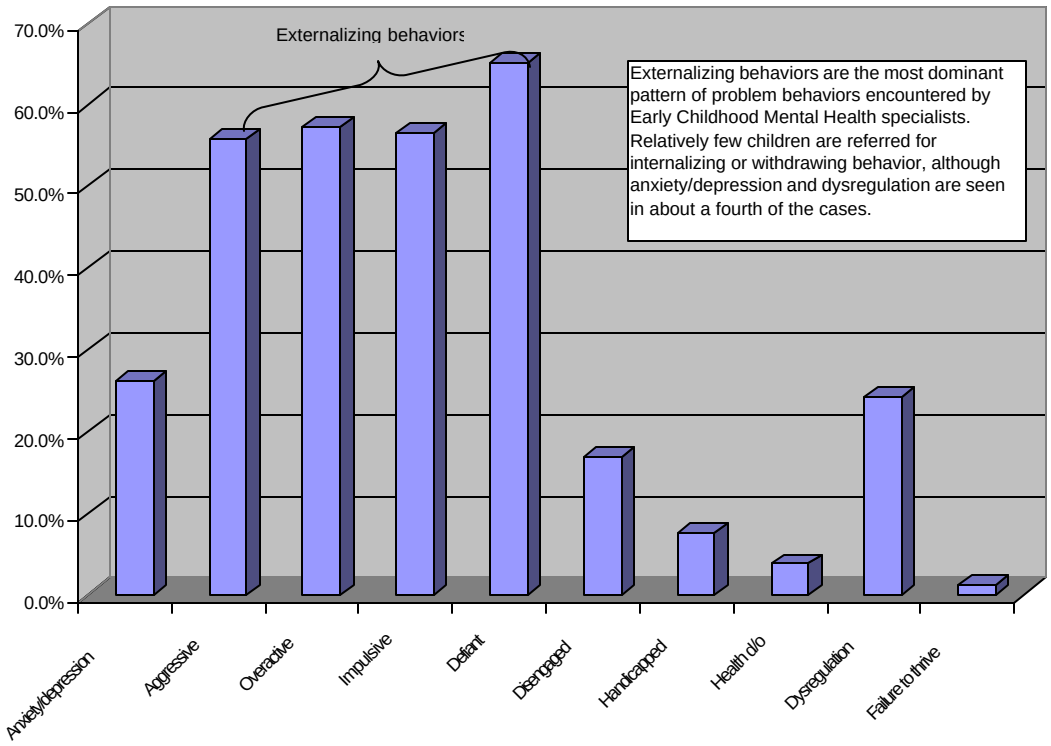
Initial information about the program for the evaluation was generated at a series of meetings in the Spring of 2003 with program managers as the initiative was being rolled out. In particular, a focus group to delineate the logic model and goals of the program was most helpful.

Due to funding and time constraints, it was not possible to gather data by visiting sites and reviewing records in detail. Additionally, the initial data-gathering system for the program was not automated and did not allow for the aggregation of data across individuals. Monthly summary reports of services provided across categories of service were available, but were insufficient to yield an unduplicated count at the individual level of service. For these reasons, and for the sake of efficiency, a structured interview methodology was chosen, in which the evaluator sought to pinpoint more precise and unduplicated numbers of individuals served and services provided within each region. Although subject to problems of potential unreliability, this method seemed more likely to yield a relatively accurate "snapshot" of the program's progress and functioning at a single point in time.

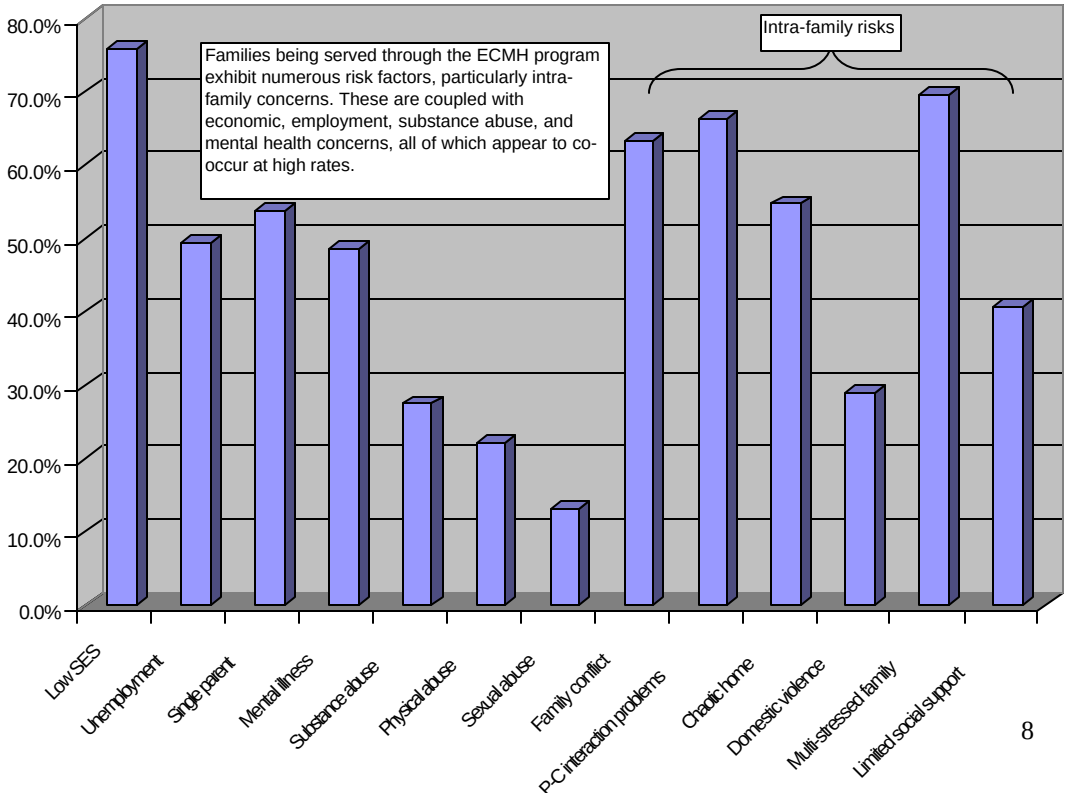
Thus, in June, 2003, interviews of about 45-minute duration were held by telephone individually with the ECMH specialist in each region. The interviews began with discussion of the coordinator's background, regional characteristics, service needs, and service array. Then, detailed analysis of the progress and extent of individual-level service offerings was accomplished (specialists had a copy of the interview format prior to the interview, and were asked to organize and aggregate their case-level data for this purpose). Then, group- and community-level intervention descriptions were obtained. These data were then aggregated, and form the basis for this report. The findings are limited, of course, to the accuracy of the data reported by each center. In general, the findings seem consistent with what centers report monthly in aggregate form, and it was felt that although they are not as precise as might be gleaned from an automated data system, for the present purpose (formative evaluation), they were sufficient.

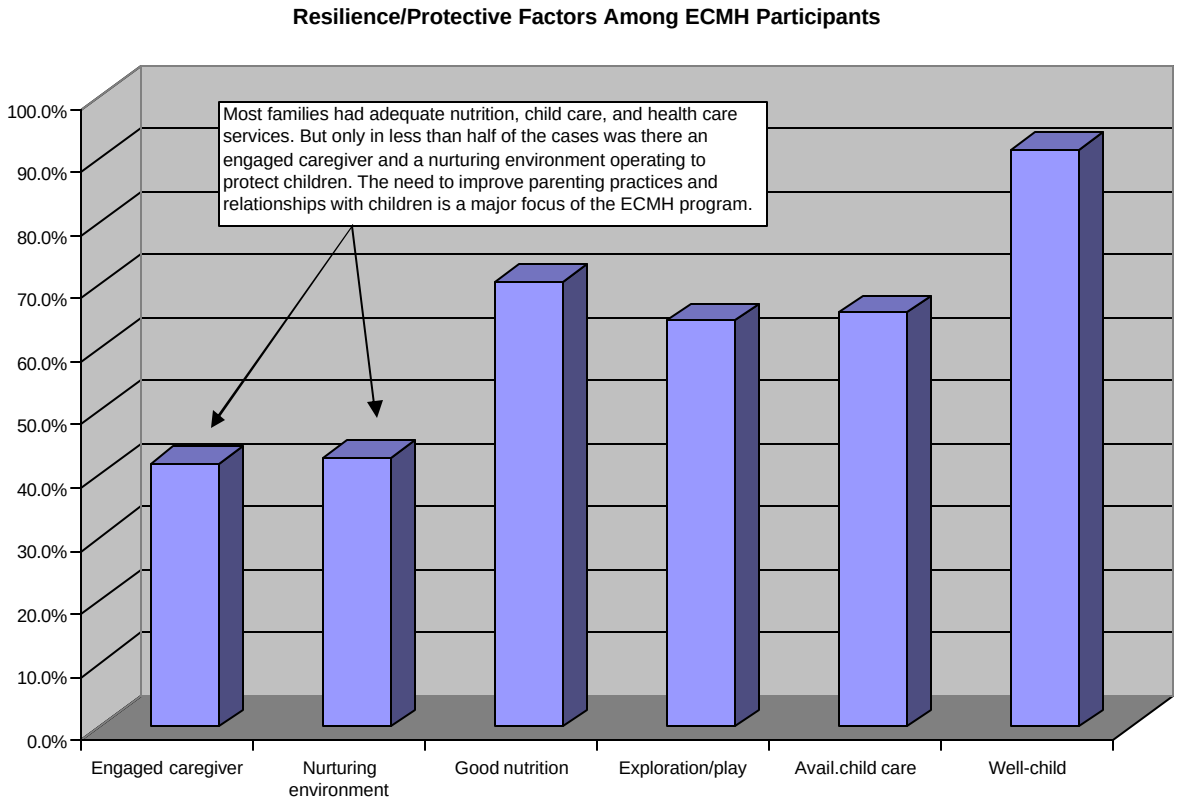
At the individual level, what are the characteristics of children and families being served?

Child Presenting Problems Among ECMH Participants



Family-Level Risk Factors Among ECMH Participants



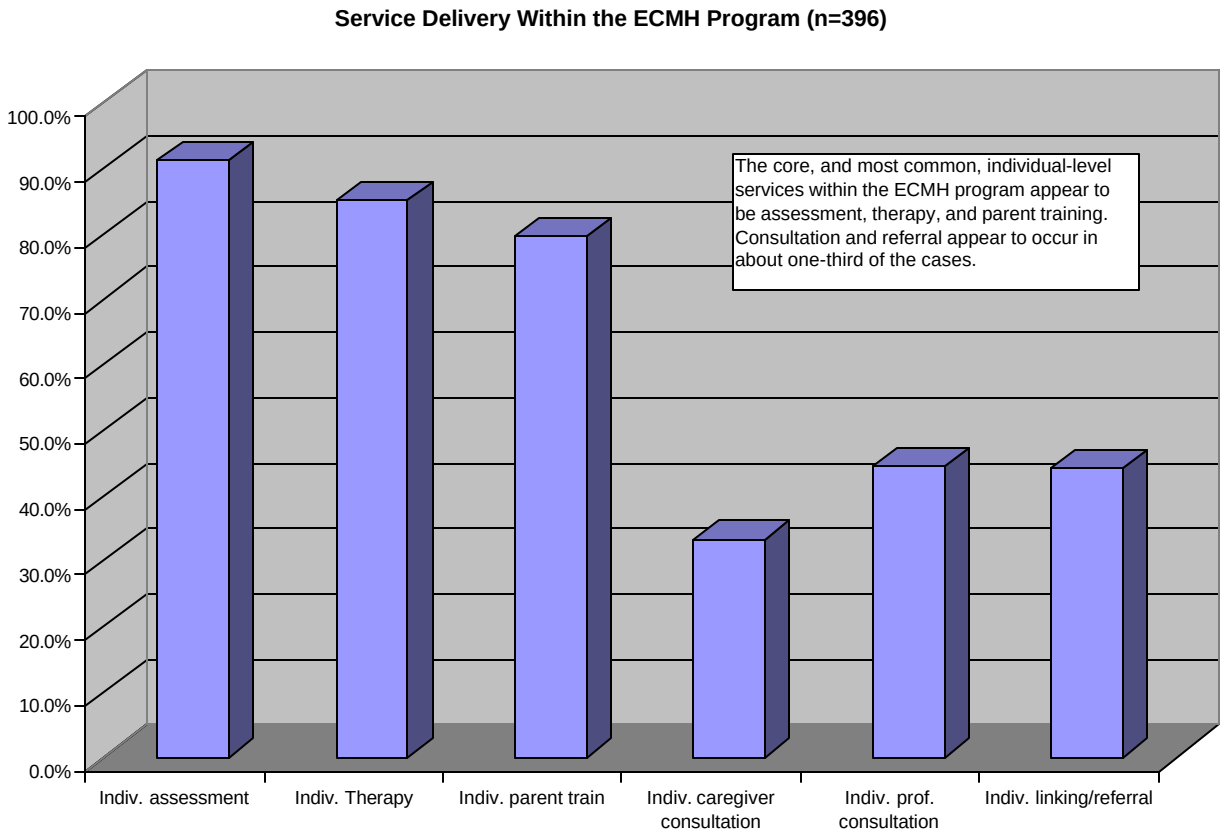


At the individual level, what are the activities that the program employs? Is the program being implemented as planned?

In effect, there are a number of core activities that ECMH specialists are expected to employ. The extent to which they do so is expected to vary by region, based on the needs and priorities identified within each Regional MH/MR Board. Core activities can be categorized as follows:

- Assessing
- Intervening
- Linking
- Coordinating
- Consulting
- Educating

Moreover, there are multiple levels and systems toward which these activities are focused: (1) child and family level; (2) program level; and, (3) community/system level.



- *Have the Regional MH/MR Boards hired and deployed qualified staff?*

  Starting dates for the programs have varied widely across regions, from the early fall of 2002 through January of 2003. At the time of this evaluation study, all regions had a program operational for a few months. Not surprisingly, they were at various stages of development. Each program was staffed by a qualified persons, although the background and training varied widely by region. More than half were staffed by individuals whose primary training and experience was in mental health, including psychologists (doctoral and master level), clinical social workers, and mental health counselors. The remaining centers had backgrounds in early childhood education, child development, and special education.

- *Have staff been engaged in activities anticipated by the program design? To what extent? Is there a relationship between the activities of the specialists and the needs of the region? How were these needs determined?*

  A range of perspectives about how to plan and operate an early childhood mental health program was evidenced among the coordinators. Most believed that there was a need to provide services at different levels of the service system, necessitating a multi-service set of program offerings. A majority organized for their role within the traditional service delivery mechanisms of the regional mental health and mental retardation board,

providing direct clinical services to children and families, supplementing this with a variety of consultation and education activities. On the other hand, in at least one setting, the coordinator took the perspective that this was not intended to be a direct service program, and therefore emphasized an indirect service model by working through other providers (especially child care settings). No individual-level services were offered in this region.

With respect to the development of programs and services, most programs seemed to fully operational and well in touch with the needs of the community. All coordinators were able to articulate the specific issues facing young children with emotional and behavioral needs in their communities, and were able to provide concrete examples of these issues. However, it appeared that the program model employed was usually less about the needs of the community, and often more about the style and beliefs of the specialist and the characteristics and preferences of the service setting. Naturally, when this provided a good match with the needs of the community, which it often did, the program operated smoothly. There were settings, however, where the program was struggling to become established. In one situation, the coordinator has not been able to generate many referrals and is challenged by issues of role definition. There are some issues around the implementation of this role in the context of community mental health centers, which generally operate within an office-based practice mode. Conducting effective outreach and delivering community-based services can present some difficulties, especially for persons who are not skilled in negotiating these issues.

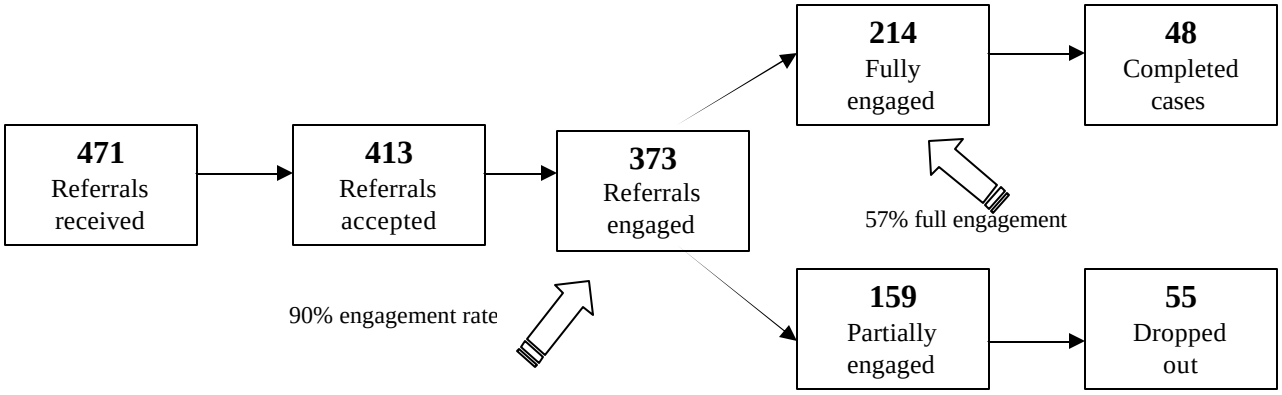
- *Are the children most in need of early childhood mental health services being identified? Where are referrals coming from? Are children being seen or served?*

The most common referral sources cited by specialists are self-referrals and referrals from child care or day care programs. Many referrals also come from First Steps, DCBS, HANDS/Healthy Start programs, and from local pediatricians and physicians. At the outset of the program, some programs had a lot of contact with local Head Starts, but this has diminished over time as resources have been targeted elsewhere.

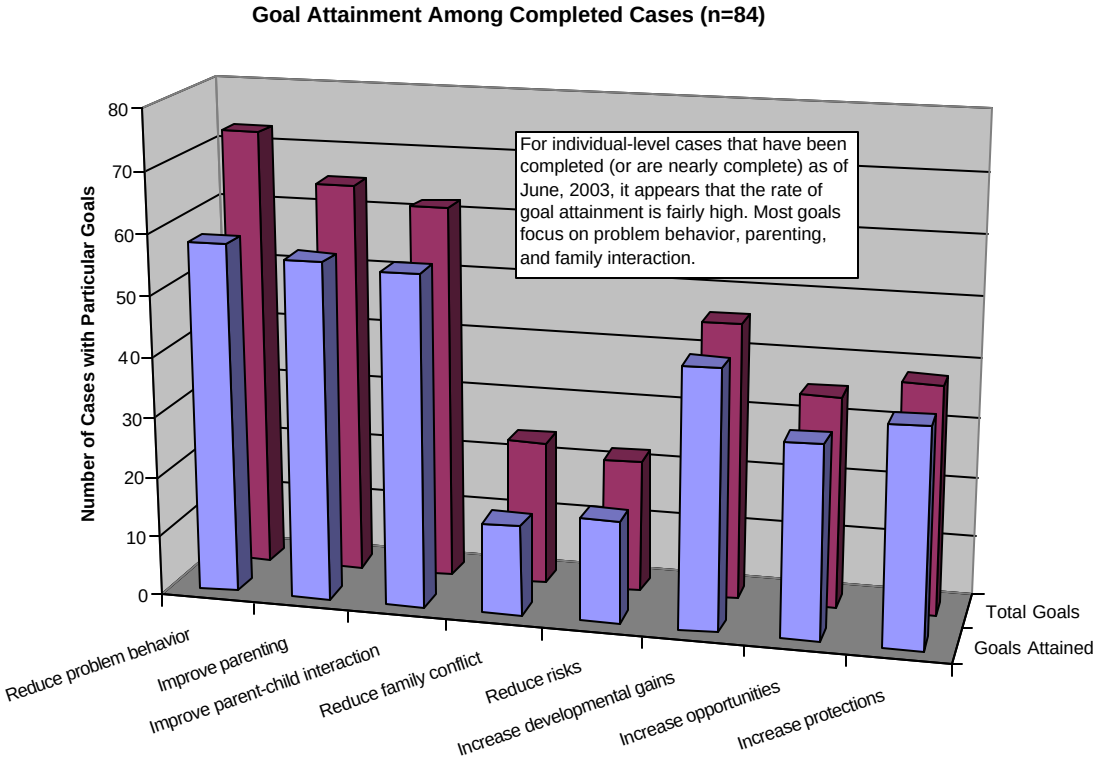
Coordinators indicate that, for the most part, they believe they are serving the children and families most in need, although all indicate that there are some families that are difficult to engage. Once referred, acceptance and engagement rates seem relatively high. It appears that centers that are more established and that have been able to establish relationships across the community receive referrals at a higher rate, and are better able to engage and serve families. There is a significant portion of participants who are described as only partially engaged (see below), and these appear to be those who show up for appointments sporadically, or only when in crisis. Outcomes for this group are not as likely to be positive, and an on-going challenge for the program is finding creative

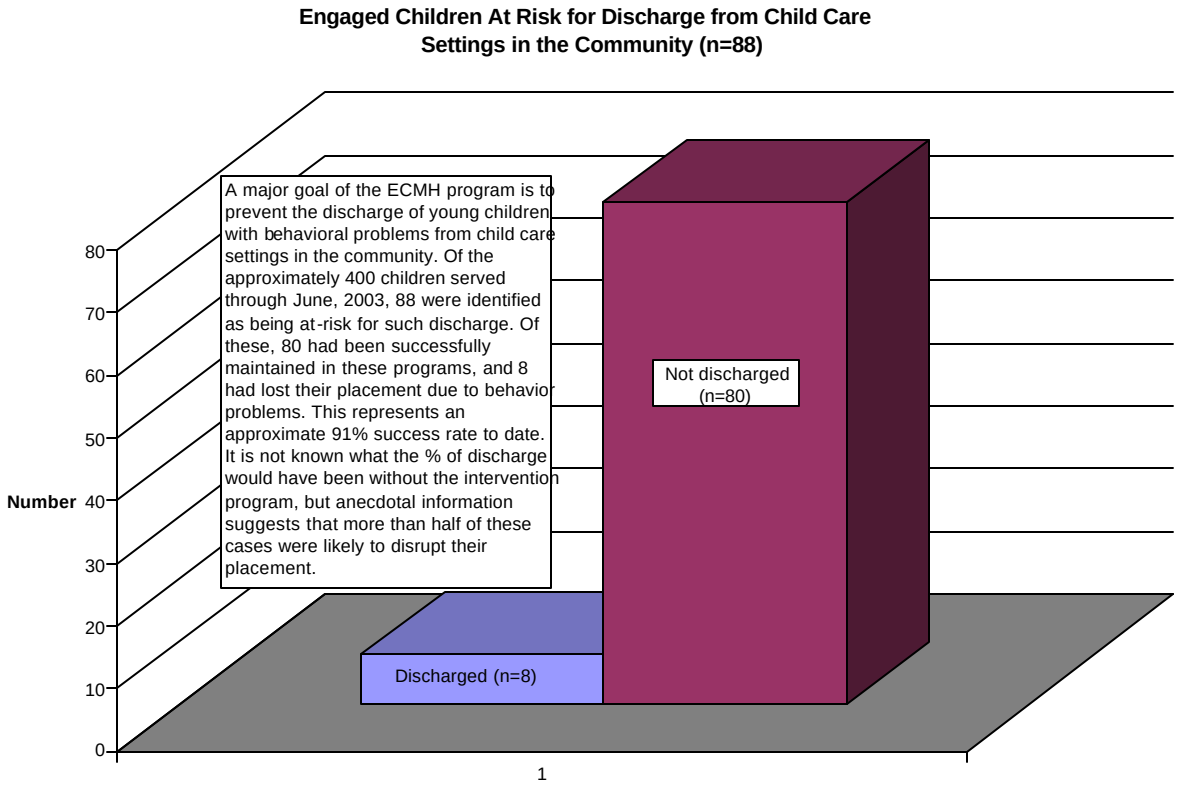
and effective ways to engage these individuals (among whom are some of the most needy).

- *How many "cases" have been initiated, processed, and/or closed as of June, 2003? What is the rate of engagement?*

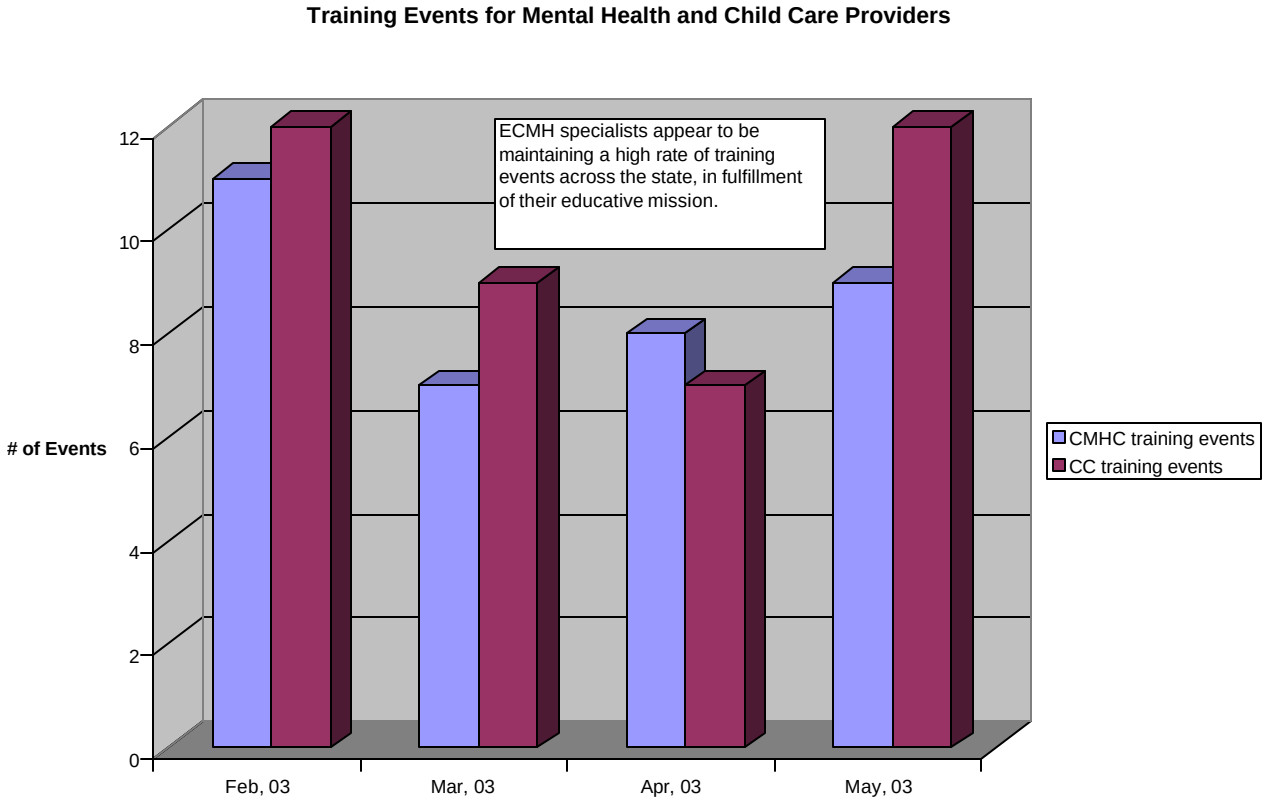


What outcomes have occurred in those cases which are completed? Problem reduction? Developmental milestones? Parenting? Safety?

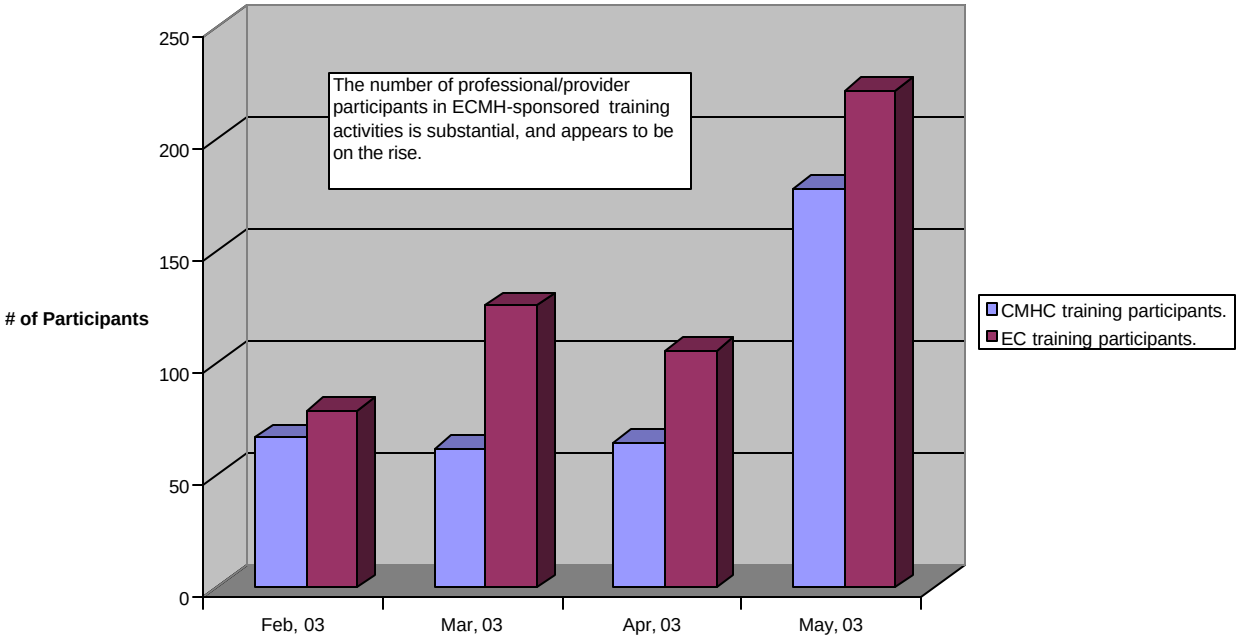




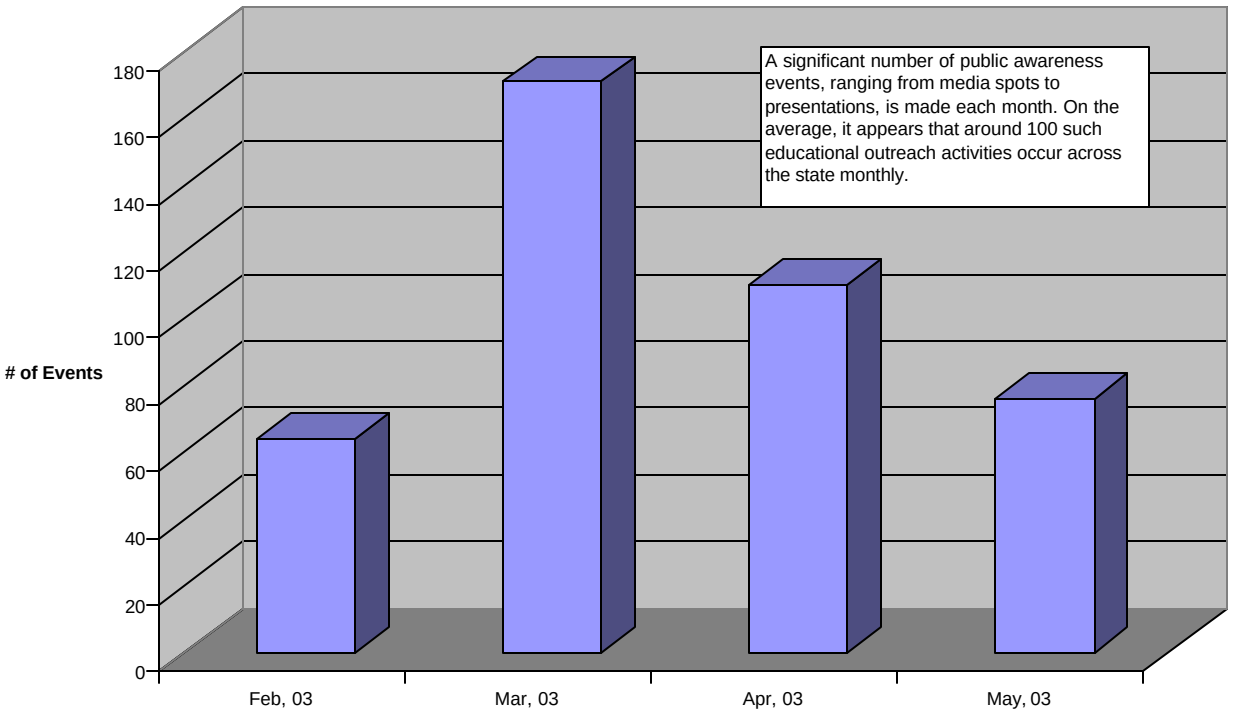
What group- and community-level interventions are being employed by ECMH specialists?



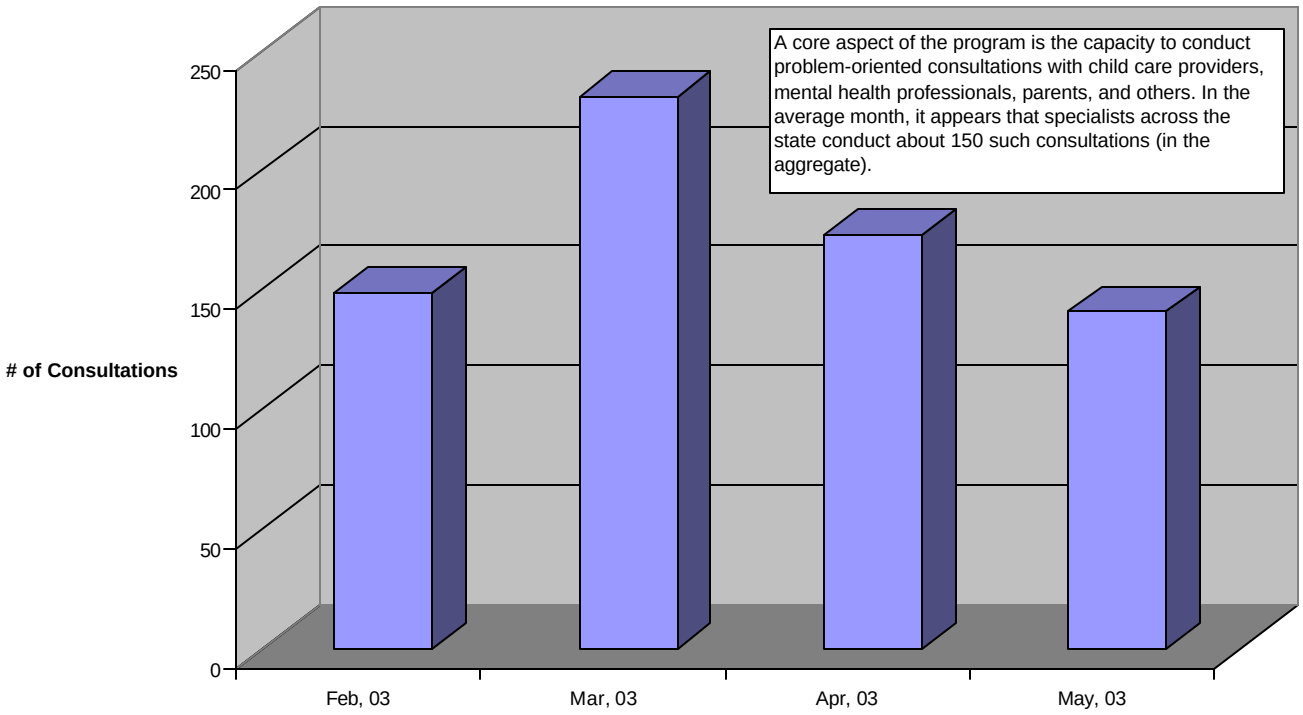
Mental Health and Child Care Providers Reached by Training Events



Public Awareness Events Conducted by ECMH Specialists



Individual- and Program-Level Consultation Events



In addition to individual-level activities focusing on children and families, ECMH specialists appear to be engaging in a wide range of broader activities targeted at group- and community-level change.

In the area of training, the most frequently cited activities conducted by ECMH specialists tend to focus on topics such as: (1) brain development in young children; (2) positive social and emotional development; (3) general principles of child development; (4) measuring change with the DECCA; (5) child behavior management; and (6) observing and charting behavior.

Most of the consultation activities conducted by ECMH specialists appear to be with two groups: (1) mental health professionals, focusing on assessment and therapy issues; and, (2) child care workers and supervisors, focusing on behavior management and child development issues.

Public awareness activities occur at varied rates across the state, although most centers appear to have done some initial “marketing” through brochures and similar methods. Some have been very active in the early stages of program development “getting the word out” through site visits and the use of media.

System-level collaboration is practiced in most centers at a high rate and includes attendance at: (1) Early Childhood councils; (2) RIAC meetings; (3) child care coalition meetings; (4) child care director meetings; (5) FRYSC council meetings; and numerous similar activities.

How is the program doing in terms of implementation? What are the biggest challenges? What successes have occurred? What can be learned from the process to date? What continuing needs exist for young children? What recommendations for developmental improvement can be made?

In general, it appears that despite being initiated quickly as funding became available and with a minimum of administrative structure, the ECMH program has gotten off to a positive start in almost all of the regions. There are noticeable differences across regions in terms of the amount of program organization and marketing that has been accomplished, in part due to the fact that some programs began operating much earlier. The key variables with respect to successful early implementation may be the skill of the specialist in carving out and communicating their role, as well as contextual factors such as the nature and needs of the service population and the organizational characteristics of the community mental health center (e.g., flexibility).

There are a number of tensions and challenges that ECMH specialists must negotiate in their organizations and communities. Some organizations are more open to non-traditional approaches and community outreach than others. An additional problem for some has been to overcome the concern about labeling and diagnosis with young children, in the context of organizations wherein all clients are expected to have an open chart and carry a reimbursable diagnosis. Relatedly, it is sometimes difficult to separate out what is a "diagnosable" mental health issue versus what is a parenting problem. Moreover, out-of-office practice and consultation models are not readily acceptable in all settings, but clinics are not always set up for work with young children. But, for the most part, specialists report that they have gotten good support from their host organization. In a couple of instances, where the program has not taken hold, what seems to be missing is administrative guidance and supervision, rather than active resistance to the program.

Specialists report frustration that needs are so great and service areas so large, that they cannot begin to find time to address all the needs. For example, in some regions, there are more than 100 child and day care organizations. Particularly at the outset of the program, there are a number of time-intensive activities, such as building relationships and "selling" the program, that need to be done to lay a proper foundation for later effort, but time does not always permit a thorough job. In most regions, initial efforts have immediately paid off in terms of referrals and requests for consultation, and balancing service provision with program planning has not always been easy. There are a couple of situations where initial marketing did not take, and resources are under-utilized. These need to be examined further, and supports need to be provided. Problems of geography and transportation are common, but not unique to this program.

An additional concern for many specialists is that the core population in most need is difficult to engage. A number report that parents will come in seeking medication or ADHD diagnoses on overactive two-year-olds (perhaps an oxymoron in and of itself), and it can be difficult to re-frame this toward an examination of parenting and child management skills. Parental isolation and illiteracy were also cited as concerns.

In this regard, since the vast majority of problems being worked on involve child management, it is recommended that greater attention be paid to the content and skills of these interventions. There are a number of empirically supported approaches for teaching early childhood parenting skills, the most prominent of which is Dr. Carolyn Webster-Stratton's comprehensive program (see links below). In addition to explicitly teaching parents micro-skills associated with play, reinforcement, limit-setting, and misbehavior, this (and similar) program focuses on the consultation skills needed to be effective.

http://www.apa.org/releases/behave.html

http://www.son.washington.edu/faculty/faculty_bio.asp?id=112

These issues notwithstanding, specialists are uniformly excited about the possibilities of the program, and report great unfulfilled needs in their communities. Child care settings in particular are most appreciative of their help, once they are able to gain entry into these organizations. Most small child care organizations do not have the resources to obtain this kind of help otherwise, and frontline workers are especially appreciative of the consultative help. When asked what kinds of specific problems child care workers are most concerned with, they almost always cite bullying, temper tantrums, and biting. Training and consultation for child care workers are seen as priority needs.